Medical Eligibility Determination (MED) Application

Name: Last_____ First_____ MI _____ Medicaid #: _____
Completed by: _____ Title:_____ Date: ___/___/_____
Agency/Organization:_____ Phone: _____

DEMOGRAPHICS

1. Gender: ☐ male ☐ female

2. DOB ___/___/_____

3. Age ___

4. Mailing Address: (primary residence)
   Street _____
   City _____
   Zip _____ Phone:_____
   County_____

5. Secondary Address:
   Street _____
   City _____
   Zip _____ Phone:_____

6. Marital Status:
   ☐ 1. Never married ☐ 4. Separated
   ☐ 2. Married ☐ 5. Divorced
   ☐ 3. Widowed

7. Number in household:
   (N/A if in facility) _____

8. Primary Language:
   ☐ 1. English ☐ 4. Other:
   ☐ 2. French Specify:
   ☐ 3. Spanish _____

9. Communication:
   ☐ 1. No assist necessary
   ☐ 2. Requires interpreter
   ☐ 3. Requires Asst. Device
   ☐ 4. Other: Specify _____

10. Assessment Trigger:
   ☐ 1. Service Need
   ☐ 2. Reassessment due
   ☐ 3. Significant change in condition

11. County: _____

   District Office: _____

12. Program Requested, Start Date ___/___/_____

HCBC-ECI:

_____

   ☐ 1. Independent
   ☐ 2. Residential Care
   ☐ 3. Assisted Housing
   ☐ 4. Adult Family Home Care
   ☐ 5. Other HCBC

Nursing Facility:

_____

   ☐ 6. ICF
   ☐ 7. SNF
   ☐ 8. Swing bed ☐ ICF ☐ SNF
   ☐ 9. Atypical ☐ ICF ☐ SNF
   ☐ 10. Out of state placement

   ☐ Private duty

13. Location at assessment and usual place of residence:
   1. Own Home
   2. Another's Home
   3. Adult Family Home
   4. Assisted Housing
   5. Congregate Housing
   6. Homeless
   7. Hospital
   8. Hotel/Motel
   9. Nursing Facility
   10. Residential Care
   11. Other:

   _____

   A. Location at assessment _____
   B. Usual place of residence _____

14. Usual Living Arrangements
   Lives with (check all that apply):
   ☐ a. Alone ☐ f. w/friends
   ☐ b. w/spouse ☐ g. w/siblings
   ☐ c. w/children ☐ h. Sig. Other
   ☐ d. w/other residents ☐ i. Other:
   ☐ e. w/parents Specify _____

15. Race/Ethnicity:
   ☐ 1. American Indian/Alaskan
   ☐ 2. Asian/Pacific ☐ 5. White
   ☐ 3. Black ☐ 6. Other
   ☐ 4. Hispanic

16. Citizenship:
   ☐ 1. U.S. Citizen
   ☐ 2. Legal alien
   ☐ 3. Other

Name: _____
Medicaid #: _____

17. Current Monthly Income Source: Applicant
- a. Earned income $ _____
- b. Social Security _____
- c. Priv. Pension _____
- d. VA benefits _____
- e. SSI _____
- f. Other _____ _____
- g. Total income _____
- h. Resources _____
- i. Unknown _____

18. Medicaid Status:
- ☐ 1. Not eligible
- ☐ 2. Eligible
- ☐ 3. Eligibility pending: App date __/__/____
- ☐ 4. No application filed

19. Potential Payment Sources:
- ☐ 1. Medicare ☐ A ☐ B ☐ C ☐ D
- ☐ 2. Medicaid
- ☐ 3. Champus
- ☐ 4. VA
- ☐ 5. Title XX
- ☐ 6. Title III
- ☐ 7. Long Term Care Insurance
- ☐ 8. Other

20. Physician:

Type: ☐ Primary ☐ Specialist
Name _____
Address _____
_____
Phone _____
Last visit date: __/__/____

Type: ☐ Primary ☐ Specialist
Name _____
Address _____
_____
Phone _____
Last visit date: __/__/____

21. Responsibility/Legal Guardian:
(Must have supporting documentation)
- ☐ 1. Self
- ☐ 2. Power of Attorney
- ☐ 3. Durable Power of Attorney
- ☐ 4. Durable Power of Attorney / HC Activated by Physician: ☐ YES ☐ NO
- ☐ 5. Guardian of Person
- ☐ 6. Guardian of Estate
- ☐ 7. Authorized Representative
- ☐ 8. Other _____
- ☐ 9. Unknown/Documentation unavailable

22. Key Contacts:

Name _____
Address _____
_____
Phone _____
Legal Guardian ☐ YES ☐ NO

Name _____
Address _____
_____
Phone _____
Legal Guardian ☐ YES ☐ NO

23. Advance Directives:
(Only for those items with supporting documentation)
- ☐ 1. Living will
- ☐ 2. Do not resuscitate
- ☐ 3. Do not hospitalize
- ☐ 4. Organ donation
- ☐ 5. Autopsy request
- ☐ 6. Feeding restrictions
- ☐ 7. Medication restrictions
- ☐ 8. Other
- ☐ 9. Unknown/Documentation unavailable

24. **CM Preference:** _____

25. ☐ MR ☐ Serious MI
SSN _____
Medicare # _____

For Office Use Only
Determination Date __/__/____
- ☐ Approved
- ☐ Denied